

SNADER

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SOME CONSIDERATIONS CONCERNING THE HEART IN RELATION  
TO ITS OWN AND OTHER MALADIES.

*A PLEA FOR THE PROPER ESTIMATION OF THE CARDIAC APPARATUS AS A SYMPTOM  
AND STATE-PRODUCING FACTOR.*

BY

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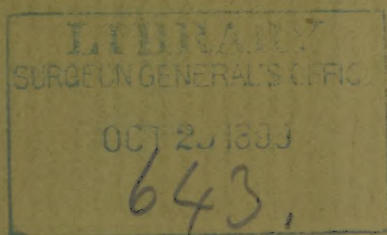
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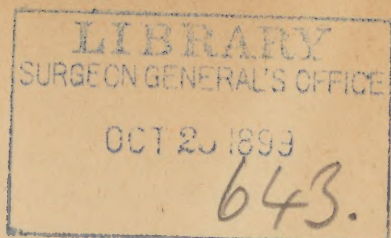
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IN this day of specialism and specialists we are prone to forget that the wonderful mechanism of the body is a unified whole, not a collection of organs differentiated from an apparent unit into a multiplication of highly-specialized, function-performing organs that have no dependence upon other parts of the body for the carrying out of the work of life.

The importance of the heart and bloodvessel system, in their power to become factors in the production of symptoms and conditions, cannot be overestimated by the general practitioner or by the specialist. The frequent dependence of diseases, apparently local in origin, upon organic or functional affections of the heart is, to my mind, a proven fact. Both the general practitioner and specialist are chargeable upon the score of insufficient investigation of disease, and there is real danger to progress in medicine in assuming that simply giving a name to a disease and treating it in a stereotyped fashion is fulfilling the physician's whole duty.

I hold that a correct diagnosis is, in the vast majority of cases of paramount importance. I hold, too, that a diagnosis must be a comprehensive one—a diagnosis of the tissue conditions involved, of the general and local effects of the lesion or state, and of the possible dependence of the condition, apparently local, upon another and maybe distant organ, or that it be of distinctive origin *in situ*; in other words, a diagnosis for the purpose of rationally applying therapeutic measures for the cure or amelioration of a disease, as well as to give name to it and furnish prognostic data.

The heart and bloodvessel system is so intimately connected with



the nutrition of all parts of the body, that the cardiac influence is frequently the dominant one, not only in acute but in chronic diseases, local and general. While the heart is the centre of nutrition, it is easily obvious that outlying conditions and diseases affect the heart both directly and indirectly. The centre influences the circumference; the circumference influences the centre.

There exists a mutual and indissoluble interdependence of the great mechanism, the human frame, and it is to this dominant interdependence of conditions and causes, playing in a consistent cycle, with which rational diagnosis, rational prognosis, and, above all, rational therapeutics, has to deal.

Related to all organs, it would seem impossible that the heart, as an underlying factor capable of producing symptoms and states of the system, and of modifying and originating local diseases and general conditions, should be overlooked in the investigation of maladies. The cardiac apparatus is often overlooked, completely ignored, and some organs are practically assumed to be able to perform their functions independently of cardiac help. In a theoretical way, in a sort of dreamy mental conception, the heart is known to be in some way connected with the nutrition of parts; but the vital fact of the absolute dependence of the economy upon the functional integrity of the heart is not *felt, sensed, LIVED*, if you please; and hence the importance of the condition of the heart and its power of modifying nutrition, and of producing symptoms and states, is overlooked or underestimated in the investigation of many local and general diseases.

In a broad sense, *the heart is back of all* disease phenomena, and of all physiological phenomena, and it is plainly our duty to justly estimate the exact *rôle* it plays in the production of symptoms directly or circuitously, and how special states or conditions boomerang back upon the circulatory centre, producing vicious pathological circles.

It seems to me obvious as a practical fact that the heart, as an organ, can be unable to perform its allotted functions fully independently of the presence of actual and discoverable organic defect. In other words, a heart, the orifices and valves of which are perfect, the cavities of which are normal, the walls of which are unaffected in their essential structural elements, may be too weak to perform its work. A cardiac apparatus, too, may be deficient in working power without the presence of any of the so-called classical functional heart diseases. It is obviously, then, not sufficient, in the in-

vestigation of a case, to examine the heart, and, finding the valves and openings perfect, and noting the absence of hypertrophy, of dilatation, of fatty degeneration, of myocarditis, to conclude that the heart is not a factor capable of causing some of the symptoms present or of modifying the whole clinical picture. The heart may possibly be the cardinal mischief-maker, notwithstanding gross pathological changes in its structure have been excluded. Of course, if a heart is obviously diseased, it is much more likely to cause symptoms than if it is not organically affected; but, on the other hand, it must not be forgotten that a diseased heart may be fairly equal to the demands usually made upon it. My plea is that the heart be measured as to its competence to perform its functions, whether it be the seat of actual disease or not.

Now, while it is true that the heart may be incapable of properly meeting the demands made upon it, it is equally true that the heart may do more than is required of it, and hence give rise to symptoms and states requiring correction. Some hearts that are obviously hypertrophied do not give rise to much systemic or local disturbance; some give rise to a great deal, and some hearts, not hypertrophied at all, occasionally, for brief periods, overact and become symptom-producing factors.

My experience shows that many headaches have a cardiac origin, dependent upon a too weak or a too strong heart. Some cephalalgias, readily referable causatively to some other than a cardiac origin, have a heart element in them that dare not be overlooked. Vertex and occipital headaches are often ameliorated by attention to the cardiac apparatus, other things being equal. Two bad cases of what might improperly be called cerebral neurasthenia were found, after careful investigation, to be dependent, one upon cerebral anæmia, due to aortic stenosis, the other upon cerebral hyperæmia, due to simple cardiac overaction. Vertigos, even symptomatically of gastric origin, are often quickly ameliorated by medicines directed more or less specifically toward the control of the circulation. In some such cases I have thought that the gastric affection was secondary to the cardiac incompetency, and that, by getting in on the "ground floor" of the symptomatic building, as it were, I was able the more speedily to afford relief.

Weak heart action, generally, however, with intermittency, in some middle-aged individuals, gives rise to a dull, indefinitely-located headache, with what might be termed graphically half-vertigo (a feeling as if they were about to become dizzy) and slow cerebration.



Tinnitus aurium, dependent upon cerebral atheroma, can often be distinctly ameliorated by dilating the arteries and strengthening the heart, if that organ be incompetent, or by soothing and regulating it, if it be too active. Murmurs are apt to be heard in the ears by patients suffering from Eustachian obstruction, and this is true whether the heart's valves be normal or not. Removal of the Eustachian obstruction, together with sedation or strengthening of the heart's action, as required, sometimes give happy results.

Even the eye does not escape the general dominance of the heart. One case (aortic stenosis and mitral regurgitation), according to an old-school oculist, had frequent retinal hæmorrhages; another mitral case had frequent alternating hemiopsia, mostly horizontal, obvious enough to her to be a decided annoyance; another had transitory anæmia of the retina; and still another (a young woman, with mitral regurgitation) had progressive myopia. Anti-syphilitic treatment failed utterly, and the only drugs that seemed to have the slightest effect in staying the progress of the malady were those having a direct tonic effect upon the heart.

Catarrhal processes of the naso-pharynx are sometimes dependent upon abnormal conditions of the gastro-enteric tract, and the latter are not infrequently secondary to weak cardiac action, and are occasionally ameliorated by direct attention to the heart. Whenever I note excessive venous engorgement, marked œdema, decided dilatation, or pulsation in the vessels, or too great redness, I examine the central organ of circulation in order to determine whether the heart is a contributing factor, directly or indirectly, to the pathological picture in the pharynx.

Epistaxis is a frequent symptom of valvular heart disease, and also occurs independently of discoverable structural change. If of cardiac origin, nasal hæmorrhage is magically controlled by regulating the circulation. I have confirmed this point many times. Such nosebleeds, however, are often conservative, and need no treatment.

The larynx is often held responsible for coughs that are really of cardiac origin. Slight catarrhal lesions may actually be present and yet not be the actual cause of cough. In other words, the pathological conditions capable of causing cough may exist and yet may be inoperative, the real cause being the irritation caused by venous congestion secondary to defective heart action. Cough is far more likely to occur when the cardiac valves are diseased than when the heart is simply functionally incompetent, but I have noted several

instances in which cough was a prominent symptom when no organic heart disease was discoverable.

In one case of laryngitis, threatening life from the marked œdema, my previous knowledge of the condition of the patient's heart, led me to suspect a cardiac cause for the œdema, and therapeutic measures, largely directed to strengthening the heart, led to rapid amelioration of the dangerous symptoms without operation.

Tracheitis and bronchitis often pursue an unduly prolonged course because of a weak heart. Chronic bronchitis is often remediable if the circulation can be rendered equable. The frequency of bronchial affections with valvular disease is too well-known to require comment, but the not infrequent dependence of that grave disorder, pulmonary œdema, upon simple cardiac weakness and alterations in arterial tension, is too little known.

The necessity of guarding the heart in acute pneumonias and pleurisies with rapid effusions ought to be the stock-in-trade knowledge of every physician. The vital need of apprehending the first signs of dilatation of the right ventricle in vesicular emphysema and fibroid phthisis is of paramount importance in the successful management of patients afflicted with such incurable maladies.

In phthisis pulmonalis the heart's ability to sustain equably the pulmonic circulation often determines the rapid or slow course of the disease. If the heart be weak, venous congestion will be greater, the arterial supply lessened, the nutrition less, the œdema increased, and the lymphatic barriers blocked by pressure.

In lung cases a knowledge of the heart's capabilities is of cardinal importance in the selection of climate. A good climate for the lungs that is a bad one for the heart may railroad a phthisical patient deathward.

Hæmoptysis is often due to the heart, but bleeding direct from the pulmonary parenchyma, can often be readily stopped by calming the circulation or strengthening the heart as required.

Intercostal neuralgias, reflex from cardiac lesions, I have frequently found it impossible to cure without direct attention to the heart itself.

Dyspepsia is quite frequently due, directly and indirectly, to cardiac weakness. Complete anorexia I have at least once traced to a cardiac cause. Dyspepsia may be due to imperfect blood supply and consequent insufficient elaboration of digestive elements. Later, nutrition becomes seriously affected, and then the heart suffers with the rest of the organism. Gases, pressing upon the pericardium,



mechanically interfere with normal cardiac action, and, with deficient nutrition, originally starting in heart weakness, or starting in the gastric sphere and ultimately affecting the strength of the heart, a vicious circle of abnormal action and reaction is established—a chain of conditions seldom permanently remediable if the heart be entirely ignored.

Aside from the fact that the liver becomes passively congested in certain valvular lesions, that viscus is sometimes the seat of engorgement as the result of simple cardiac weakness, and then supplies a multitude of rectal, visceral, and indirect cerebral symptoms, all primarily dependent upon insufficient power in the cardiac pump, yet giving little indication of their origin in the totality of the merely symptomatic picture.

All organs in relation with the abdominal sympathetic are affected by the heart and in turn affect the heart. Cardiac failure, with prolonged and dangerous syncope was a pronounced feature in two cases of every-day colic seen by me, one, a sufferer from aortic stenosis, who was confined to bed for two weeks after the subsidence of the intestinal torture on account of the condition of the heart alone, and in another, a young woman of twenty-three, without discoverable organic cardiac disease, was pulseless and cold to the shoulders during and after the subsidence of the pain. For over three weeks this patient had to be kept absolutely quiet, as the mere raising of the head from the pillow would cause the heart to suspend its action.

The exceeding frequency of gastro-enteric catarrh, upon which some attacks of colic depend, and which disease, independently of pain, occasionally gives rise to most atypical clinical pictures, I have often traced to previously unsuspected valvular lesions; but have sometimes found the catarrhal process to depend upon simple cardiac inefficiency, or the heart was rendered weak, in some instances by the same toxic influences of which the gastro-enteric tract was eliminative or originative, as in gout, rheumatism, lithæmia, Bright's, etc.

The maladies known collectively as Bright's disease all affect the heart more or less directly, especially, of course, the cirrhotic kidney. However, it must not be forgotten that clinically Bright's is not typically of the text-book variety, but is often mixed, *i.e.*, may have one or more predominating elements of one of the fixed forms and shade off into the pathological processes characteristic of others. The alterations in the heart muscle itself, in the arterial walls, and in vessel tension, are responsible for multitudinous pathological pro-



cesses. The giving way of the right or left ventricle is sometimes the first sign of a final break up in the interstitial form. Without the possibility of controlling the general and local circulation the chances of cure or amelioration in this class of cases is, to my mind at least, problematical. Without a fairly-sound heart it is impossible to cure Bright's of any variety.

Menstrual vagaries, in my rather limited gynæcological experience, I have occasionally found dependent upon organic heart disease, and exceptionally, it is true, upon simple circulatory weakness. Uterine hæmorrhage, menorrhagia, suppressed menses, so-called congestive dysmenorrhœa, have yielded to therapeutics directed specifically to the heart. Where decided tissue changes had occurred, as in purulent endometritis, I have not succeeded with medicines alone, but have seconded the remedy by direct local treatment.

Recurring acute attacks of hæmorrhoids, in cases of mitral disease, without general symptoms indicating rupture of compensation, have yielded to cardiac therapeutics more rapidly than to the usual medicaments.

Sexual disorders, including even what I would call passive prostaticorrhœa, have twice or thrice been ameliorated by attention to the heart. The cardiac symptoms sometimes complained of by this class of cases are not always reflex from a sexual source. The heart may really, in a certain sense, be the prime cause of the disorder, simply manifesting its own weakness at the weakest part of the patient's anatomy.

The spinal nervous system, as well as the cerebral, often presents groups of symptoms typically neurasthenic, that are primarily dependent upon cord anæmia or engorgement. Improvement in the circulation, in such cases, has led to some unexpectedly rapid curative results.

Professor J. N. Mitchell, in a paper read two years ago before the State Society, called attention to the danger attending pregnancy and labor in women suffering from organic heart disease; and I can confirm his observations in many particulars. But, aside from the time of actual labor, during the lying-in period the heart is not unfrequently responsible for a delay in involution. It must not be forgotten that the heart must involute, in a certain sense, as well as the uterus. Attention to the heart will sometimes materially hasten the destructive and reconstructive processes. My guide as to the propriety of allowing a woman to be about after confinement, is not the number of days since the birth of her babe, but the condition of the

heart as well as the condition of the uterus, other things being equal. I have kept some women in bed a month or six weeks after confinement simply on account of the heart's condition.

Jerks when going off to sleep, nervous tremor, and cramps in the legs, are sometimes found in cardiac cases. A peculiar, dry, scaly condition of the skin of the extremities is occasionally traceable to a cardiac cause. "That tired feeling," and severe aching in the limbs and muscles, is also sometimes found when the heart is weak.

Now, while I am strongly of the opinion that the cardiac apparatus is frequently underestimated as a symptom and state-producing factor, I am convinced that, in certain cases, too much attention, or rather, ill-advised attention, is given the heart in some of the acute diseases—as pneumonia and typhoid fever. Certain maladies, in the course of their life history, produce so-called heart failure, by virtue of degenerative tissue changes, and it is of immense practical importance to have a knowledge of the diseases in which such failure is likely to supervene. Usually, the general condition of the patient gives warning of the possible or potential presence of waning heart power. But, this is not always so. I have seen decided cardiac failure in the first five days of the lightest kind of typhoid fever (that is, really before an absolutely positive diagnosis could be asserted), the patient presenting no visible evidences of parenchymatous tissue degeneration, the temperature being so low as to scarcely warrant the suspicion, much less the assumption, of grave muscle-fibre changes. Most of such cases of early cardiac failure, however, result from indiscretions on the part of patients. There is no legitimate reason for beginning drug-treatment to sustain the heart simply because cardiac failure is among the possibilities of the disease. This brandishing of the sword of drug power in the absence of the foe, leaves the therapeutic arm palsied when real danger appears, and almost assures defeat, unless the sufferer's cardiac apparatus be miraculously strong. In other words, to treat with drugs a possible cardiac failure that is three weeks or three days in the womb of the future, is not in accord with the dictates of common sense. Such treatment exhausts the heart's muscular irritability when there exists no immediate need to call upon its scanty reserve force. When the first skirmish line of heart failure appears, then is the time, and then only, to commence active drug and stimulant treatment, directed specifically to the sustaining of the muscular and nervous energy of the heart, and carry on the circulation with reasonable equability. If such tactics are adopted the fight for life may prove only a skir-



mish, and real, appalling heart weakness may not appear. Now, while drugs and stimulants are usually not needed early, therapeutic measures looking toward the preservation of the strength of the heart, are of cardinal importance—such as absolute rest, easily-assimilable diet, proper bathing, to quiet nervous irritability, cause sedation of the vaso-motor system, and lower temperature. All these measures tend to keep up the heart's strength, and are, in many instances, all that is necessary.

In diphtheria, I do not wait for direct signs of cardiac failure, but commence bold, general stimulation, even before the slightest evidence of sepsis appears, because I know that with sepsis I shall have to deal with a myocarditis or cardiac palsy, and, besides, the *acute danger period* is short lived.

The condition of the heart after the subsidence of acute affections, I am quite sure is often ignored, and patients suffer unnecessarily long and tedious convalescence in consequence. I have been compelled to keep a pneumonia patient in bed three weeks after the subsidence of the acute symptoms, on account of the precarious condition of the heart alone, and this, too, in spite of the fact that in the crises the temperature fell only to normal. The patient declared himself absolutely well, color came to his cheeks, he increased in strength and appetite, and his tongue and temperature were normal. Yet, if raised to the sitting posture, his pulse went to pieces, and syncope occurred or impended. Verily, the sum total of the subjective symptoms presented by a patient is not the sum total of his disease, or of his condition. The physician alone, not the patient, should make the decision as to the actual condition.

After typhoid I have noted a pulse of 100 to 120 for six weeks to three months after apparent complete recovery. I watch such patients closely and feed and drug them judiciously.

After diphtheria it is almost a crime to permit a patient to do anything but eat and stay in bed for two or three weeks.

Although the heart does become affected in vesicular emphysema and in fibroid phthisis, so long as nature has compensated sufficiently for the stress upon the right ventricle, there is no call for specific interference on account of the heart, but the moment the first signs of cardiac weakness supervene the major portion of therapeutic attention should be given the heart, for upon the heart's integrity depends the lengthening of the life of the patient.

Now, while the cardiac apparatus, in acute and in some chronic maladies, often receives mal-attention, the heart, when it is the seat

of orificial or valvular malformations, is sometimes subjected to unnecessary and injudicious treatment. The prescribing of drugs specifically for the heart simply because its openings and valves are imperfect is utterly useless and often positively injurious. A heart whose lesions are perfectly compensated requires no treatment whatever, other things being equal. The condition of the heart as a pump and a vital organ alone require consideration. The patient, not the disease, is the sole important factor. These observations, however, do not apply to acute or recent lesion of the endocardium, following or coincident with the many diseases of which endocarditis is a sequence. Here long rest after the subsidence of the graver phenomena, as emphasized by Prof. William C. Goodno, will result in less valvular or orificial distortion than would occur if the patient were allowed to be governed by his subjective sensations and feelings of well-being. During this sub-acute period of endocarditis, and, indeed, for a long time afterward, medicines having the power of promoting the absorption of inflammatory products and of limiting connective tissue growth and contraction, will be of service, and assist materially in minimizing the inevitably resulting damage.

A myocarditic heart, a fibroid heart, a fatty heart, should receive therapeutic attention from the first moment of recognition, whether occurring as a distinct or complicating affection, independently of the symptoms complained of.

What are the diagnostic criteria to be depended upon in determining the competency of the heart to perform its functions—in determining the solvency of the bank of life and its ability to pay out its wealth of blood corpuscles in its commerce with the creditor capillaries.

The signs of cardiac decadence or inability differ greatly in different cases. Sometimes exceedingly slight modifications of the heart sounds or intervals are all the evidences present, and often considerable concomitant and corroborative testimony of cardiac inefficiency is obtainable. In some very rare instances, the problem of cardiac competency is simply a suspicion, and here direct experimentation with drugs specifically acting upon the cardiac muscle only decides the question. Independently of the diagnostic signs of organic heart disease, which may or may not be present in a given case, other evidence of the heart's weakness is available for the purpose of solving the question of the competency or incompetency of the cardiac apparatus. Of course, when organic disease is present, exact



allowance must be made for the modifications of the heart sounds and intervals that belong to the disease, else grave errors may be committed. If the impulse be weak, if the first sound be short, "muffled," "muddy," "gasey," and conveys the idea of sluggishly moving muscle, or makes you think of a fairly big impulse with little power back of it, and if this first sound is nearly as high pitched as the second, if it is less intense than the second sound, if the interval in the long pause of the heart's revolution be shortened, if the interval between the systolic and diastolic sounds be lengthened, that heart requires direct therapeutic attention, whether classical organic disease be discovered or not, and whether those signs be interpreted as meaning beginning dilatation or as meaning muscular and nervous incompetence or not. If the systolic sound loses its muscular quality and becomes like the second, imminent danger is at hand. If very moderate motion decidedly and pronouncedly accelerates the heart action much beyond the physiological limits, and causes the heart to be irregular, intermittent, tumultuous in action, and ventricular asynchronism develops, that heart needs looking after. If the first sound heard over the tricuspid area is only about half as loud as that over the region of the apex, and the left ventricle is not hypertrophied, other things being equal, the right heart requires more attention than the left. If the first sound of the heart is of the same intensity over both the tricuspid and mitral areas, other things being equal, the left ventricle is the one under most stress. Such hearts are weak, if nothing more, and require strengthening.

If the second sound of the heart be lower in pitch than the first the arterial system is relaxed. If the second sound be decidedly accentuated over the pulmonic area, and no valvular or orificial lesions are present and the adjacent lung tissue is free from disease, there exists increased tension in the pulmonary circuit. If the aortic second sound be decidedly accentuated, and the lungs are not solidified and the left ventricle is not hypertrophied, the tension in the arterial circuit is raised, or there exists arterio-fibrosis or atheroma, aortitis or aneurism. Such hearts may or may not require attention. The diseases causing the increased tension may require most treatment, or you may call upon the heart to assist in overcoming the mechanical obstacles, for these obstacles eventually succeed in overwhelming the heart. Every such case is a law unto itself so far as the question of therapeutics is concerned.

If the impulse be strong and *all* the heart-sounds are simply intense and clear-cut, and reasonably preserve their normal disparities

of pitch and quality, and the action is rapid, the heart not being hypertrophied, and the stomach and abdomen not distended with gases, the lungs being free from disease, and there being no sthenic fever present, and local and general throbbings are complained of, you are dealing with an over-active heart. Such beats are usually strong, and require sedation.

When it is discovered that the heart is weak, only the threshold of the problem of possible relief has been reached. It must be ascertained whether the heart itself is intrinsically weak; whether its incompetence is exactly balanced with a present associated malady; whether its condition is simply a part of a general running down of the vital forces; whether its asthenia is dependent upon a mechanical cause near by or distant from the organ; whether upon a nervous cause; whether upon insufficient nourishment from disease of its supply-arteries, from poor blood, or from poisoned blood. The solution of this problem may require the exhaustive examination of many organs adjacent to and remote from the heart, and an elaborate analysis of the symptoms.

The next point to decide is whether the heart requires rest or exercise; whether it requires direct stimulation; whether it is wisest to reach it indirectly by hypernutrition; whether the poisoned blood shall first (as in Bright's, lithæmia, rheumatism and gout), be eliminated of its toxic materials, or physiological drugging go hand in hand with the eliminative and hygienic measures, and whether the treatment of the disease, of which the weak heart is a complication and symptom-producing factor, will be all that is necessary. Sometimes the vaso-motor system must be regarded as part of the cardiac apparatus, and sometimes the vessel-moving mechanism must be conceived of as a separate and distinct system.

The necessary judgment-balance to solve such a problem will soon be acquired by a careful clinical observer—by one not given to the method of making “inspiration” diagnosis at a range of four feet. I say this without sarcasm. I know personally that one can be woefully deceived by symptoms alone. Symptoms are not reliable. Symptoms interpreted by signs speak volumes. The heart's condition can never be accurately determined by mere symptoms, no matter how typical. I have been fooled too often on this point. I have seen cases that, prior to a physical examination, I would have sworn were cardiac ones. The most elaborate, careful, painstaking, and repeated explorations, however, failed to reveal anything discoverably abnormal in the heart. Some of these cases presented



deathly dyspncea, due, as the examination taught me, to vaso-motor spasm or relaxation. The converse of this general proposition is also true. Cases turn out to be cardiac ones, after a careful general examination and analysis of symptoms, that at first glance presented not the slightest suspicion of being cardiac.

While I believe the heart is a possible symptom- and state-producing factor in many diseases not specifically cardiac, I do not want to be understood as wishing to give the heart undue importance. But, that a vital necessity exists of giving the cardiac apparatus a due amount of attention, I most seriously contend. I repeat, both general practitioners and specialists neglect the heart.

A New York specialist in throat diseases recently treated, and with fair success, too, a post-nasal catarrh, the patient meanwhile being swollen to the knees from cardiac dilatation. Had he been able to see those legs through his head-mirror he might have been still physician enough to have sent the patient where he belonged, or to have treated him more rationally. Another stomach specialist treated a man for so-called nervous dyspepsia until he was dropsical to the umbilicus from combined cardiac and renal disease, the "dyspepsia" being secondary to these dire diseases, and not specifically a local matter at all. Here the heart was totally neglected.

It was my misfortune to be personally cognizant of the treatment received by a young lady suffering from a form of tonsillitis that, even without the simplest medical attention, would have recovered in three or four days, who took only, in the course of twenty-four hours, only fifty grains of salicylate of soda, because the throat affection was probably rheumatic; only a tablet composed of one-eighth minim each of aconite, bryonia and belladonna every two hours for the fever; only applications of hot water to the throat externally as a local sedative; only gargles of guaiacum and Listerine as a local antiseptic and corrective; only one-eighth grain of morphia hypodermically at night to relieve the dysphagia, and only five drops of digitalis every three hours, because the pulse intermitted—only these and nothing more. It is a wonder that only a pansy blossom and an obituary notice did not complete the clinical picture. What magnificence of therapeutic resources, and what a paucity of judgment with which to apply them. One wonders what such a man would do were he to stand in the presence of appalling disease disaster, where life hung in the balance, and exquisite judgment was demanded.

I by no means wish to make every disease a cardiac one, but it is

just these two extremes of non-attention and unnecessary attention that I wish to inveigh against.

I present this paper as a general practitioner, not as a heart specialist. If it be charged, however, that it is the paper of a specialist, I have but to reply that that is the sort of specialist every general practitioner ought to be, and, further, that's the sort of a general practitioner every specialist ought to be.

I make no apologies for the lack of literary merit in my paper. Sounding sentences and fetching phrases are not consonant with the succinctness with which time compels me to deal with this subject. I am well aware that a lengthy and possibly profitable paper could be written on every single proposition that I have advanced. I know of no work extant that treats specifically of the heart in relation to general diseases, and I have been compelled to draw from my personal experience in presenting the subject in this broad and suggestive way. Just how much of this paper is the stock-in-trade knowledge of all physicians, and just how much is original, is a matter of indifference to me so long as I am able, by even this kaleidoscopic and imperfect glance over the field, to give emphasis to the necessity of properly estimating the cardiac apparatus as a symptom- and state-producing factor. I have only been able, in this short time, to limn out in rough perspective a picture of the possible clinical individualization of cases. You may be able to fill in the finer details.











